



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy three times a week for four weeks, left shoulder

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering shoulder problems

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Forensic Associates forms
2. TDI referral forms
3. Denial letters, 04/13/10, 04/22/10, and 04/26/10
4. Clinic notes, M.D., six entries between 01/15/10 and 04/19/10
5. Fax cover letter, 05/13/10
6. MRIOA Peer Review, 04/12/10 and 04/26/10
7. Preauthorization request
8. Physical therapy prescription and evaluation plan of care, 04/07/10
9. Letter requesting reconsideration, 04/20/10

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male with a date of injury of xx/xx/xx. The mechanism of injury is not documented. Surgery in September 2009 included an arthroscopic surgical procedure for impingement syndrome and partial tear of rotator cuff. No operative report is provided. He was provided with a rehabilitation program of physical therapy post surgery and completed at least 25 or more sessions of physical therapy. Recently a request has been

submitted for an additional twelve sessions of physical therapy, three times a week for four weeks. The exact indications for such additional therapy is not clear; however, the implication is that strengthening is required of the shoulder girdle musculature involving motion of the left shoulder. This request has been considered and denied, reconsidered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The ODG 2010 Shoulder Chapter, Physical Therapy passage, recommends 24 visits of physical therapy over fourteen weeks after arthroscopic shoulder surgery for rotator cuff repair. Such therapy sessions have been provided. There is no specific indication to justify medical necessity for additional physical therapy at this time. The patient's home exercise program can be directed to both maintenance of range of motion and muscular strengthening on a home exercise self-supervised program.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Cervical Spine Chapter, Discography passage.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)